Joint Legislative Oversight Committee on Medicaid and NC Health Choice

Overview of Medicaid Dashboards November 2016

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Discussion Guide

- **Purpose of Dashboards and Presentation**
- **Enrollment Observations**
- **Enrollment Mix Observations**
- **Utilization and Price Observations**
- **Summary – Follow ups/Things the General Assembly should know or monitor**

***** Key definitions attached at the end of the presentation***

Purpose of Dashboards and Presentation

- **The Dashboards are intended to provide a comprehensive set of "early warning" indicators and predictors.**
- **The goal is to provide context prior to the DMA budget presentation and their analysis of spending at each meeting.**
- **The plan is to work closely with DMA and OSBM to ensure meaningful conversation about trends.**
- **The Dashboards will probably raise more questions than provide answers.**

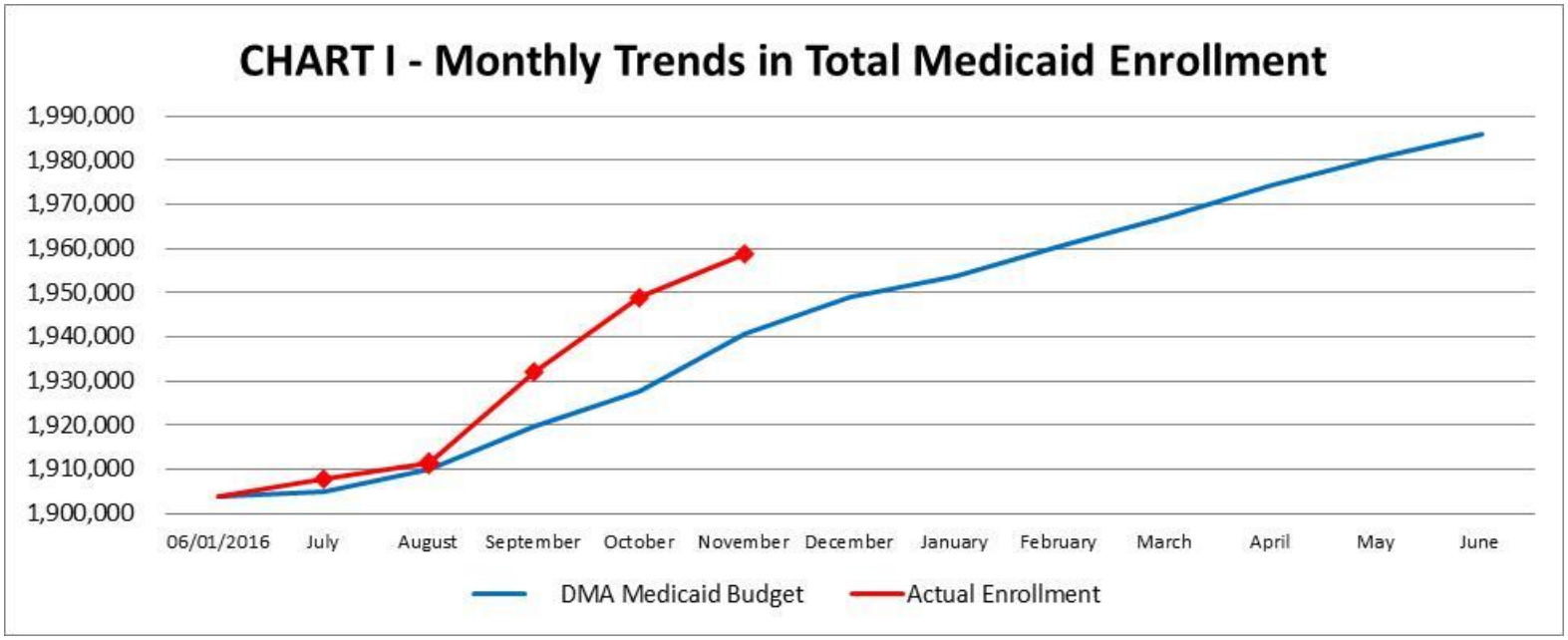
Caveats – 1) It is still early in the year and;

2) Dashboards and indicators are only as good as the data we have

Key Drivers of Medicaid Claims Spending = Enrollment + Mix + Utilization + Price

- The Dashboards are not a forecast of future spending – BUT should help guide assumptions used to develop future forecasts.
- The Dashboards are a look back at the drivers and spending through a "point in time" compared to what was budgeted during that period of time.
- A vital role of variance analysis is the identification of what is different than what you expected it to be…..then deciding what corrective action plans to consider.
- Through 11/29/16 the dashboards raise questions about enrollment trends, county enrollment changes, spending in specific categories and transactions in non-claims spending.

Enrollment Observations - Overall

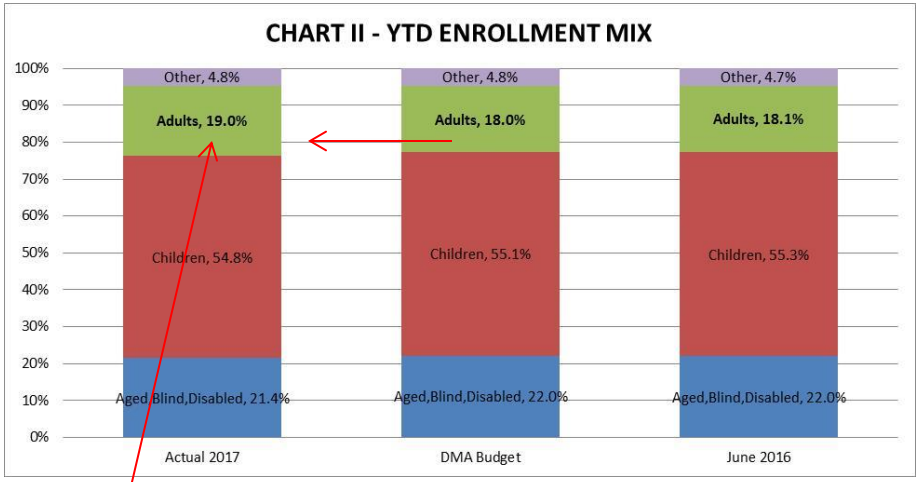


- Overall Medicaid enrollment is 1% over DMA's original forecast in November 2016.
- Enrollment as a macro indicator of spending appears to have been fairly neutral for the first two months with an uptick in last three months in AFDC adults, Children and Disabled populations.
- To understand spending, the next area to focus on is enrollment mix.

SOURCE: DMA Forecast and Website - http://dma.ncdhhs.gov/about/statistics-and-reports.

Enrollment Observations - Mix

- The fact that there are 17,941 more enrollees than DMA forecasted in November alone can be a misleading indicator for understanding how/why spending compares to budget.
- YTD Adults are 19% of total enrollment a 5.6 % variance from budget. A primary factor in the increase is the higher than budgeted growth in Family Planning enrollment–20,173 (15.4%) over DMA's forecast and Legal Aliens that are 3,980 or 33.9% over DMA's forecast.
- Family Planning costs are budgeted at less than $8 PMPM compared to the average budgeted PMPM of $509.



Shift to adult populations

- Without Family Planning and Legal Aliens, enrollment would be under budget, equally important the areas most under budget are the most costly program aid categories – ABD are collectively 8,144, or 1.9%, under budget.

Collectively all the factors identified above would predict spending less than DMA's forecast.

SOURCE: DMA Forecast and Website - http://dma.ncdhhs.gov/about/statistics-and-reports.

Enrollment Observations - Detail

		YTD Actual	DMA Budget	Variance	Prior Year End	*Change*
Breast and Cervical Cancer		395	380	15	380	15
Adj Illegal Aliens		22	1,170	(1,148)	10	12
Disabled		292,607	299,122	(6,515)	292,045	562
AGED		125,492	127,031	(1,539)	124,257	1,235
Blind		1,683	1,773	(90)	1,687	(4)
Other Child		5,956	5,931	25	5,752	204
MPW		17,937	18,055	(118)	18,137	(200)
AFDC > 20		202,178	199,857	2,321	199,813	2,365
MQBQ	Dual Eligibles	8,365	9,557	(1,192)	8,123	242
MQBB	Dual Eligibles	43,083	45,029	(1,946)	43,619	(536)
MQBE	Dual Eligibles	24,962	24,419	543	23,438	1,524
Refugees		972	1,201	(229)	960	12
Aliens Legal		15,727	11,747	3,980	12,751	2,976
AFDC <21		505,095	511,133	(6,038)	490,704	14,391
MIC		432,712	428,950	3,762	430,681	2,031
MCHIP		130,285	124,348	5,937	125,334	4,951
Family Planning		151,346	131,173	20,173	126,098	25,248
TOTAL		1,958,817	1,940,876	17,941	1,903,789	55,028

AREAS FOR QUESTIONS

1) Higher cost aged blind and disabled under budget-**$1,430 PMPM**
2) Lower cost non-CHIP children under budget - **$228 PMPM**
3) MCHIP increased 4.8% compared to NCHC 3.5%
4) Legal Aliens largest % growth category and largest % budget variance
5) AFDC adults over budget and children under, 70% of counties had adults growing faster than children
6) "Adj Illegal Aliens" reporting is not consistent DMA's original forecast

SOURCE: DMA Forecast and Website - http://dma.ncdhhs.gov/about/statistics-and-reports.

Enrollment Observations – County Trends

- **Outlier counties are defined as those with a net decrease since June 2016 or increased more than 2.5%. There are 11 that reflected a decrease in enrollment and 31 with increases over 2.5%. Collectively the outlier counties represented 51.7% of the total Medicaid enrollment in November 2016. As expected, these counties disproportionately impact trends.**

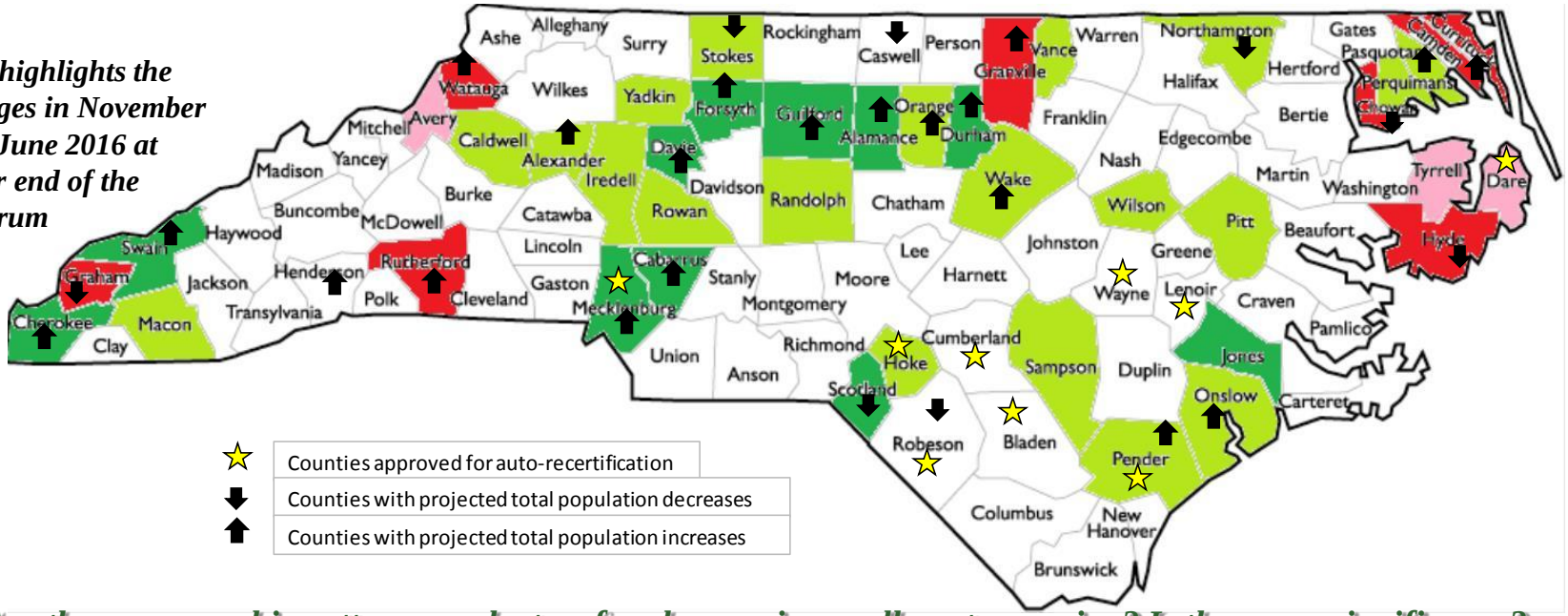
- **ABD** – 74.3% of total ABD change was in these 42 counties; 47.5% of the overall ABD enrollment is in these counties.
  - *Counties that declined had an average .3% decline in ABD and those that increased over 2.5% in total reflected a .7% ABD increase; compared to an overall growth in ABD of .4%.*
- **CHILDREN** – 97.8% of Children growth is in these 42 counties; 52.6% of the overall Children enrollment in these counties.
- **AFDC** – 99.2% of AFDC growth is in these 42 counties; 51.8% of the overall AFDC enrollment in these counties.
  - *Counties that declined had an average 3.1% decline in AFDC and those that increased over 2.5% in total reflected a 5.1% AFDC increase; compared to an overall growth in AFDC of 2.4%.*
- **DUALS** – 1.6% of Duals growth is in these 42 counties; 46% of the overall Duals enrollment in these counties.
  - *Counties that declined had an average 4.5% decline in Duals and those that increased over 2.5% in total reflected a 2.2% Duals decrease; compared to an overall decrease in Duals of 1.2%.*

Enrollment Observations – County Trends

Trends in counties vary – a key question is whether they indicate process or policy changes with future implications for Medicaid spending or just changes in demographics?

> 1.0% Decrease | 0 to 1.0% Decrease | 2.5 to 4.0% Incr | > 4.0% Increase

Map highlights the changes in November over June 2016 at either end of the spectrum



- ***Are there geographic patterns or clusters for changes in enrollment emerging? Is there any significance?***
- ***Are patterns in enrollment consistent with predicted changes in general county population? If not why?***
- ***What role, if any, is auto-recertification playing in county enrollment trends prior to the hurricane?***
- ***Impact of recent hurricane?***

SOURCE: DMA Website - http://dma.ncdhhs.gov/about/statistics-and-reports and OSBM

Spending - Claims Variance Observations

	7/12 YTD	7/19 YTD	7/26 YTD	8/1 YTD	8/9 YTD	8/16 YTD	8/23 YTD	8/30 YTD	9/6 YTD	9/13 YTD	9/20 YTD	9/27 YTD	10/4 YTD	10/11 YTD	10/18 YTD	10/25 YTD	11/1 YTD	11/8 YTD	11/15 YTD
Enrollment	$ (3.6)	$ (5.7)	$ (7.9)	$ (10.0)	$ (12.2)	$ (14.4)	$ (16.5)	$ (18.7)	$ (20.2)	$ (21.6)	$ (23.1)	$ (24.6)	$ (25.8)	$ (26.9)	$ (28.1)	$ (29.3)	$ (30.7)	$ (32.1)	$ (33.4)
Crossover Claims Recovery						$ (14.7)	$ (29.7)	$ (44.7)	$ (44.7)	$ (44.7)	$ (59.3)	$ (59.3)	$ (59.3)	$ (59.3)	$ (59.3)	$ (59.3)	$ (59.3)	$ (59.3)	$ (59.3)
Utilization and Price	$ (5.4)	$ (7.9)	$ (5.3)	$ (14.5)	$ (14.4)	$ 2.2	$ 3.9	$ 9.8	$ 13.9	$ (15.4)	$ (14.1)	$ (20.0)	$ (43.9)	$ (11.4)	$ (22.0)	$ (28.5)	$ (62.5)	$ (54.2)	$ (63.9)
TOTAL CLAIMS VARIANCE *in Millions*	$ (9.1)	$ (13.7)	$ (13.1)	$(24.5)	$(26.6)	$ (26.9)	$ (42.3)	$ (53.6)	$(51.0)	$ (81.8)	$ (96.5)	$(103.8)	$(129.0)	$ (97.6)	$(109.4)	$(117.0)	$(152.4)	$(145.5)	$(156.6)

- Through the 11/15/16 checkwrite, NCTracks spending is $157 million less than budgeted in total requirements, which can be associated with the following factors:
  - *$33.4 million resulting from enrollment and mix variances*
  - *$59.3 million resulting in a one time recovery from reprocessing Medicare cross-over claims in August and September*
  - *$63.9 million from variances in timing, utilization and pricing.*

Need to identify which are recurring and which are non-recurring

- At a macro level, through the 11/15/16 checkwrite, spending in total requirements on capitation, physician services, hospital IP/ER, lab & xray, PCS, and drugs, include areas with the greatest contribution to the $63.9 million timing, utilization and pricing variance.
- Variance attributable to timing, utilization and pricing requires additional analysis from the Department to understand or identify any trends in spending and implications for future months.

SOURCE: DMA weekly checkwrite reports , monthly PER reports and DMA forecast model/OSBM.

Utilization and Price Observations

A PMPM analysis helps guide a discussion of utilization and price compared to budget

	FY 2016-17 PMPM	FY 2015-16 PMPM	Change	% Change	Budget	Variance	% Variance
LME/PIHP/PACE/Med Solutions	$ 118.42	$ 126.06	$ (7.64)	-6.1%	$ 127.03	$ (8.60)	-6.8%
Pharmacy Gross - Before Rebates	$ 79.88	$ 81.30	$ (1.42)	-1.8%	$ 87.02	$ (7.14)	-8.2%
Physician Services	$ 48.04	$ 53.72	$ (5.69)	-10.6%	$ 55.92	$ (7.88)	-14.1%
Skilled Nursing Facilities	$ 52.57	$ 55.60	$ (3.03)	-5.5%	$ 54.32	$ (1.75)	-3.2%
Hospital Inpatient Services	$ 41.21	$ 39.41	$ 1.79	4.5%	$ 44.05	$ (2.84)	-6.5%
Hospital Outpatient Services	$ 21.36	$ 22.89	$ (1.53)	-6.7%	$ 22.27	$ (0.90)	-4.1%
Personal Care Services	$ 18.45	$ 21.57	$ (3.12)	-14.5%	$ 19.83	$ (1.38)	-7.0%
Hospital Emergency Room Services	$ 16.11	$ 16.70	$ (0.59)	-3.5%	$ 18.27	$ (2.16)	-11.8%
Dental	$ 15.95	$ 17.21	$ (1.26)	-7.3%	$ 16.36	$ (0.41)	-2.5%
CAP Disabled Adult Services	$ 10.56	$ 10.67	$ (0.11)	-1.1%	$ 11.33	$ (0.78)	-6.8%
Durable Medical Equipment Services	$ 8.79	$ 9.37	$ (0.58)	-6.2%	$ 9.52	$ (0.73)	-7.7%
Clinic Services	$ 4.94	$ 5.81	$ (0.87)	-14.9%	$ 5.15	$ (0.20)	-4.0%
Lab & X-Ray Services	$ 4.43	$ 5.48	$ (1.05)	-19.1%	$ 7.03	$ (2.60)	-37.0%
Home Health Services	$ 5.43	$ 5.59	$ (0.16)	-2.8%	$ 6.03	$ (0.59)	-9.8%
Practioner Non-Physician Services	$ 5.24	$ 5.43	$ (0.19)	-3.5%	$ 5.78	$ (0.54)	-9.4%
CAP Children Services	$ 4.64	$ 4.80	$ (0.16)	-3.3%	$ 5.77	$ (1.13)	-19.6%
Health Check Services	$ 4.53	$ 5.09	$ (0.56)	-11.0%	$ 5.64	$ (1.11)	-19.6%
Hospice Services	$ 3.11	$ 3.19	$ (0.08)	-2.4%	$ 3.14	$ (0.03)	-0.8%
Ambulance Services	$ 0.75	$ 1.81	$ (1.06)	-58.5%	$ 1.56	$ (0.81)	-51.9%
Hosp Inp/Outp Mental	$ 1.15	$ 1.10	$ 0.04	4.0%	$ -	$ 1.15	
LTC NSO	$ 0.05	$ 0.07	$ (0.02)	-29.9%	$ -	$ 0.05	
CAP MR	$ 0.00	$ 0.01	$ (0.00)	-53.7%	$ 0.00	$ 0.00	1206.1%
High Risk Intervention	$ 0.00	$ 0.01	$ (0.01)	-90.4%	$ 0.00	$ (0.00)	-82.3%
Adult Care Homes	$ -	$ (0.00)	$ 0.00	-100.0%	$ -	$ -	
LTC SO	$ -	$ (0.00)	$ 0.00	-100.0%	$ -	$ -	
All Other	$ 3.68	$ 4.18	$ (0.49)	-11.8%	$ 3.21	$ 0.48	14.9%
TOTAL	$ 469.30	$ 497.07	$ (27.76)	-5.6%	$ 509.21	$ (39.91)	-7.8%

Categories of Service where cost on a PMPM is higher than budget or prior year

When analyzing spending it is important to prepare a PMPM analysis based on total requirements and not appropriations, since changes in federal share, rebates and other receipts can mask trends in actual consumption and utilization. Spending should be evaluated separately from receipts to understand options to corrective action and where DMA stands against assumed or budgeted spending.

SOURCE: DMA forecast, monthly PER reports and Website - http://dma.ncdhhs.gov/about/statistics-and-reports

Overall Medicaid Spending Observations

Thus far we have focused on claims spending because it represents nearly 90% of the total requirements budgeted for Medicaid, ***however other funds can have a significant impact on overall appropriations compared to budget.***

	Actual YTD Requirements	Actual YTD Receipts	Actual YTD Appropriation	DMA YTD Approp Budget	Year to Date Variance	Percent Variance
DMA Administrtation and Contracts	74,916,432	55,601,957	19,314,476	18,414,364	900,112	5%
Other Administration	-	-	-	-	-	
Claims and PMPMs	3,976,116,404	2,662,514,225	1,313,602,180	1,360,054,394	(46,452,215)	-3%
Settlements	81,125,618	54,876,552	26,249,065	5,750,930	20,498,136	356%
Program Integrity	(18,140,629)	(16,966,012)	(1,174,617)	(8,821,764)	7,647,147	-87%
Rebates	(319,363,149)	(164,414,087)	(154,949,061)	(120,225,543)	(34,723,518)	
Supplemental Payment	893,016,280	937,312,908	(44,296,628)	(52,242,790)	7,946,162	
Undispositioned Receipts	(6,620,896)	39,003,783	(45,624,679)	-	(45,624,679)	
Adjustments and Other	(3,114,625)	(70,684,969)	67,570,344	45,337	67,525,007	
Total Spending	4,677,935,436	3,497,244,357	1,180,691,079	1,202,974,927	(22,283,848)	-2%
Receipts as a % of Requirements		68.3%		67.9%	0.4%	

SOURCE: DMA forecast and BD701, OSBM.

Spending reflects year to date amounts through October 31, 2016

Overall Medicaid Spending Observations

Administration	$ 900,112
Supplemental	7,946,162
Federal Share of Rebates	(49,440,046)
Other Rebate Variance	14,716,528
Adjustments	21,900,329
TOTAL	(4,877,027)
Claims and Services	(18,306,932)
TOTAL MEDICAID	$ (22,283,848)

- The $46 million variance on the previous slide in claims and PMPMs includes $10 million as a result of mix and $20 million from reprocessing crossover claims, which leaves $16 million resulting from unidentified volume, use and price differences.
- Settlements need to be analyzed to determine how much of the $20 million variance over budget is timing vs spending higher than budget.
- Total requirements for rebates are $25 million or 7.2% under-budget compared to an appropriations variance of $35 million, therefore, it appears the variance in rebates is more of a function of federal receipts not paid back yet than higher recovery of rebates.
- Variances in supplemental, undispositioned receipts and adjustments need to be segregated between timing, federal changes, trends and other to understand future implications for spending.
- The 4% variance in receipts for admin/program spending needs to be reviewed by DMA.

SOURCE: Calculated from DMA forecast and BD701.

Summary – Follow Up

- Enrollment - *Family Planning and Legal Alien enrollment trends; and variations between and trends in Counties. Are there policy, practice or demographic changes that will impact future months spending?*

- Claims spending – *Capitation, Physicians, I/P& E/R Hospital, Lab & Xray, PCS and Drug spending and non-NCTracks components of spending implication for future months. Can DHHS identify any trends, utilization changes or other factors that would indicate whether this is more about timing or a "real" change in consumption?*

- Claims are not the only expenditure to consider in Medicaid – *Undispositioned receipts and adjustments, federal share of drug rebates and supplemental payments had a significant impact on overall Medicaid appropriations needed year to date. Variances in these accounts, other than rebates more than offsets the $22.3 million variance under budget at 10/31/16. How much is timing versus a "real" change in spending and how this will impact future months and expectations of spending.*

- Federal and other changes that may impact future spending – *Are Medicare Part B premium increases projected consistent with budget assumptions and what factors are contributing to the higher than budgeted receipts percentage through 10/31/16?*

QUESTIONS

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Definitions

- ABD – *aged, blind and disabled enrollment category*
- AFDC – *aid to families with dependent children/TANF*
- Auto-recertification – *process approved by DHHS monthly to allow a county to automatically extend Medicaid eligibility for one month without a review for administrative reasons*
- CAP – *community alternatives program*
- CAP MR – *community alternatives program/mental retardation*
- CHIP – *children health insurance program, a federal program that applies to children not covered by Medicaid up to 210% of the federal poverty level. Funded by an allotment rather than an entitlement*
- Children – *includes AFDC <21, MIC, MCHIP and other children enrollment categories*
- DMA – *Division of Medical Assistance*
- Duals – *includes aged, MQBQ, MQBB and MQBE enrollment categories*

Definitions

- IP/ER – *hospital inpatient and emergency department services paid by Medicaid*
- LME – *local management entities*
- LTC NSO – *long term care/non-state owned*
- LTC SO – *long term care/state owned*
- MCHIP – *children aged 0 to 5 from 133% to 210% of the federal poverty level*
- MIC – *infants and children*
- Mix – *the distribution of enrollment categories or service spending*
- MPW – *pregnant women*
- MQBQ/MQBB/MQBE – *individuals dually eligible for Medicare & Medicaid*
- NCHC – *North Carolina Health Choice program for children from 133% to 210% of the federal poverty level*
- OSBM – *Office of State Budget and Management*
- PIHP - *prepaid insurance health plans*

Definitions

- PACE – *capitated program for elderly*
- PCS – *personal care services paid by Medicaid*
- PMPM – *per member per month or cost per enrollee per month*
- Program Integrity – *amounts recovered from providers for fraud, waste and abuse, as well as third party recoveries where the individual has another source of payment in addition to Medicaid*
- Settlements – *payments made to cost based providers to reconcile estimated claims payments to cost based on a submitted cost report*
- Supplemental Payment – *include payments to hospitals for disproportional share hospital payments (DSH), additional payments to hospitals funded by assessments or intergovernmental transfers for the difference in claims payments and costs, additional payments to hospitals funded by assessments or intergovernmental transfers for the difference in costs for inpatient services and what Medicare would pay, and additional payments to UNC and ECU physicians for the difference in Medicaid claims payments and an average commercial rate*

Definitions

- Utilization – *the quantity, frequency or type of services consumed*
- YTD – *year to date*